

DESCRIBE THE CONTROLS YOUR ORGANIZATION HAS IN PLACE TO BACKUP THESE PERSONS IN THE EVENT THEY ARE NO LONGER EMPLOYED BY YOUR ORGANIZATION OR CANNOT COMPLETE THESE TASKS.

DOCUMENTATION OF MEALS AND SUPPLEMENTS SERVED MUST BE MADE AT POINT OF SERVICE. POINT OF SERVICE IS DEFINED AS THE PLACE AND TIME AT WHICH MEALS ARE SERVED. PLEASE DESCRIBE BELOW HOW YOUR ORGANIZATION ENSURES THAT MEALS ARE DOCUMENTED AT POINT OF SERVICE.

HAS THIS INSTITUTION, OR ANY OF ITS PRINCIPALS, SPONSORED FACILITIES, OR KEY STAFF OF SPONSORED FACILITIES EVER BEEN TERMINATED IN ANY STATE FOR BEING SERIOUSLY DEFICIENT IN OPERATING ANY UNITED STATES DEPARTMENT OF AGRICULTURE (USDA) CHILD NUTRITION PROGRAM AND PLACED ON THE NATIONAL DISQUALIFIED LIST?

☐ YES ☐ NO

DURING THE LAST SEVEN YEARS, HAS THIS INSTITUTION OR ANY OF THIS INSTITUTION'S PRINCIPALS BEEN DECLARED INELIGIBLE FOR ANY OTHER PUBLICLY FUNDED PROGRAM BY REASON OF VIOLATING THAT PROGRAM'S REQUIREMENTS?

☐ YES ☐ NO

DURING THE LAST SEVEN YEARS HAS THIS INSTITUTION OR ANY OF ITS PRINCIPALS BEEN CONVICTED OF ANY ACTIVITY THAT INDICATED A LACK OF BUSINESS INTEGRITY (FRAUD, ANTITRUST VIOLATIONS, EMBEZZLEMENT, THEFT, FORGERY, BRIBERY, FALSIFICATION OR DESTRUCTION OF RECORDS, MAKING FALSE STATEMENTS, RECEIVING STOLEN PROPERTY, MAKING FALSE CLAIMS, OBSTRUCTION OF JUSTICE, OR ANY OTHER ACTIVITY INDICATING A LACK OF BUSINESS INTEGRITY)?

☐ YES ☐ NO (IF YES, GIVE DETAILS ON NAME OF PERSON)

LIST THE FEDERAL, STATE OR LOCALLY FUNDED PROGRAMS IN WHICH THIS INSTITUTION AND ITS PRINCIPALS HAVE PARTICIPATED IN THE PAST SEVEN YEARS.

HAVE YOU EVER BEEN FOUND TO BE IN NONCOMPLIANCE OF THE CIVIL RIGHTS LAWS BY ANY FEDERAL AGENCY?

☐ YES ☐ NO

IS THIS BUSINESS MINORITY OWNED AND OPERATED?

☐ YES ☐ NO

IS THIS BUSINESS A REGISTERED WOMAN OWNED AND OPERATED BUSINESS?

☐ YES ☐ NO

CIVIL RIGHTS REVIEW (MUST BE COMPLETED BY FIRST TIME APPLICANTS)

Collection of racial/ethnic data is for statistical reporting and in no way affects program participation. For information on the racial/ethnic make-up of your area, check with the local Chamber of Commerce, the public library, or the public school system in your area. For racial/ethnic make-up of the participants in the facility, use visual identification or parental report to determine the racial/ethnic category.

	PERCENT RACIAL/ETHNIC MAKE-UP OF THE POPULATION OF THE AREA TO BE SERVED.	ACTUAL NUMBER OF PARTICIPANTS ENROLLED IN THE CENTER BY RACIAL/ETHNIC CATEGORY.
AMERICAN INDIAN OR ALASKAN NATIVE	%	
ASIAN	%	
BLACK OR AFRICAN AMERICAN	%	
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	%	
WHITE	%	
WITHIN EACH CATEGORY ABOVE, INDICATE HOW MANY ARE OF HISPANIC OR LATINO ETHNICITY		

TYPE OF FACILITY (Be sure to choose the correct box under the appropriate heading).

DOES THE ORGANIZATION OWN OR OPERATE MORE THAN ONE FACILITY?

☐ NO☐ YES (if yes, check all that apply)**CHILD CARE CENTER**

- ☐ NONPROFIT CHILD CARE CENTER, HEAD START OR LICENSE-EXEMPT CHILD CARE CENTER [must be tax-exempt by the Internal Revenue Service. (501c(3) organization)] **Submit a copy of your 501c(3) letter.**
- ☐ FOR-PROFIT CHILD CARE CENTER [must be receiving state child care subsidy money from the Dept. Social Services-Family Support Division (FSD) for at least 25% of enrolled children or 25% of license capacity, whichever is less; or have 25% of enrolled children eligible for free or reduced price meal reimbursement].
- ☐ EMERGENCY OR HOMELESS SHELTER
- ☐ GOVERNMENT OPERATED CHILD CARE CENTER

OUTSIDE SCHOOL HOURS CARE CENTER

- ☐ NONPROFIT OUTSIDE SCHOOL HOURS CARE CENTER [a center that only cares for children before or after school, and is a tax-exempt 501c(3) organization].
- ☐ FOR-PROFIT OUTSIDE SCHOOL HOURS CARE CENTER [must be a for-profit center caring for children before and after school and must be receiving state child care subsidy money from the Family Support Division for at least 25% of enrolled children or 25% of license capacity, whichever is less].
- ☐ NONPROFIT AT-RISK AFTER SCHOOL PROGRAM [center must be located in an area served by a school where 50% or more of children enrolled in that school are eligible for free or reduced price school lunches. Must be a tax-exempt 501c(3) organization].
- ☐ FOR-PROFIT AT-RISK AFTER SCHOOL PROGRAM [must be caring for children in an at-risk setting, as described above, and must be receiving state subsidized child care payments from the Family Support Division for at least 25% of enrolled children or 25% of license capacity, whichever is less; or have 25% of enrolled children eligible for free or reduced price meal reimbursement].
- ☐ GOVERNMENT OPERATED AT-RISK AFTER SCHOOL OR OUTSIDE SCHOOL HOURS PROGRAM

ADULT DAY CARE CENTER [Adult day care centers may not receive Title III of the Older Americans Act funding if participating in the CACFP].

- ☐ NONPROFIT ADULT DAY CARE CENTER [must be a licensed, tax-exempt, 501c(3) organization, caring for adults in a nonresidential setting].
- ☐ FOR-PROFIT ADULT DAY CARE CENTER [must be receiving Title XIX payments for at least 25% of enrolled adults in a nonresidential setting].

CENTER ADMINISTRATION

- ☐ LEGAL ENTITY OF THE SPONSOR
- ☐ LEGALLY SEPARATE FROM THE SPONSOR

IS THIS A LICENSED CENTER?

☐ YES ☐ NO

IS THIS ORGANIZATION AFFILIATED WITH A RELIGIOUS ORGANIZATION?

☐ YES ☐ NO

PLEASE SELECT THE MONTH(S) OF OPERATION (SELECT ALL THAT APPLY)

OCT NOV DEC JAN FEB MAR APR MAY JUN JUL AUG SEP

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

BOARD MEMBERS, OWNERS, DIRECTORS, AND OTHER ORGANIZATION PRINCIPALS

IN THE TABLE BELOW, LIST ALL BOARD MEMBERS, OWNERS, EXECUTIVE DIRECTORS, DIRECTORS AND OTHER PRINCIPALS OF THE ORGANIZATION, WHO ARE RESPONSIBLE FOR THE FINANCIAL VIABILITY AND ACCOUNTABILITY OF THE ORGANIZATION. ATTACH ADDITIONAL SHEETS IF NECESSARY. (will be verified with the Missouri Secretary of State)

NAME OF INDIVIDUAL	TITLE/POSITION	ADDRESS	DATE OF BIRTH (required)

TO BE COMPLETED BY SPONSORING ORGANIZATIONS ONLY (A SPONSORING ORGANIZATION IS AN ORGANIZATION THAT OWNS, OPERATES, OR SPONSORS MORE THAN ONE FACILITY)

STAFFING PLAN

LIST THE ORGANIZATION'S NORMAL BUSINESS HOURS OF OPERATION:

☐ SUNDAY ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY

OPEN TIME: _____ A.M. P.M.

CLOSE TIME: _____ A.M. P.M.

HOW DO YOU ASSURE THAT EACH SPONSORED FACILITY IS LICENSED OR LICENSE-EXEMPT DURING THE TIME PERIOD OF THE AGREEMENT? (IT IS THE RESPONSIBILITY OF THE SPONSORING ORGANIZATION TO ASSURE THAT EACH FACILITY UNDER ITS SPONSORSHIP IS CURRENTLY LICENSED OR LICENSE-EXEMPT AND INSPECTED. MDHSS WILL NOT TRACK THIS INFORMATION FOR THE SPONSOR. FACILITIES THAT ARE NOT LICENSED OR LICENSE-EXEMPT FOR THE ENTIRE CLAIM PERIOD ARE NOT ELIGIBLE FOR CACFP REIMBURSEMENT DURING PERIODS WHEN NOT LICENSED.)

IF YOU ARE A SPONSOR OF FOR-PROFIT FACILITIES, HOW WILL YOU ASSURE THAT EACH FACILITY RECEIVES FUNDS UNDER TITLE XX OR TITLE XIX (FOR ADULT DAY CARE FACILITIES) OF THE SOCIAL SECURITY ACT FOR AT LEAST 25 PERCENT OF ITS ENROLLMENT (OR FOR CHILD CARE FACILITIES ONLY, ENROLLMENT OR LICENSED CAPACITY, WHICHEVER IS LESS), DURING THE MONTH PRECEDING APPLICATION TO THE CACFP AS WELL AS DURING EACH MONTH CLAIMED FOR REIMBURSEMENT? (AT A MINIMUM, THE SPONSOR MUST COLLECT AND REVIEW FSD INVOICES AGAINST THE CENTER'S ENROLLMENT TO ASSURE THAT 25% OF ENROLLED PARTICIPANTS ARE TITLE XX AND/OR TITLE XIX RECIPIENTS.)

DOES THE SPONSOR OR ANY OF THE FACILITIES UNDER THE SPONSOR, CONTRACT WITH A FOOD SERVICE MANAGEMENT COMPANY (CATERER) FOR MEALS?

☐ NO ☐ YES IF YES, ATTACH COPIES OF THE CONTRACT AND THE PROCEDURES USED TO SELECT THE FOOD SERVICE MANAGEMENT COMPANY.

FEDERAL REGULATIONS REQUIRE THAT ORGANIZATIONS OBTAIN CATERED SERVICES IN A COMPETITIVE MANNER IF THE ANNUAL CONTRACT FOR SUCH SERVICES WILL EXCEED \$100,000. THE INSTRUCTIONS ON THE COMPETITIVE BID PROCESS AND A COPY OF A BID PROTOTYPE FOR CONTRACTS ABOVE \$100,000 CAN BE FOUND AT: WWW.DHSS.MO.GOV/CACFP.

FOR ANY FACILITY OPERATING A PRICING PROGRAM, HOW DO YOU ENSURE THAT THE FACILITY COLLECTS PAYMENT FOR MEALS IN ACCORDANCE WITH THE APPROVED POLICY STATEMENT? (PRICING PROGRAM MEANS AN INSTITUTION IN WHICH A SEPARATE IDENTIFIABLE CHARGE IS MADE FOR MEALS SERVED TO PARTICIPANTS).

IN THE CHART BELOW, LIST THE STAFF MEMBER WITH PRIMARY RESPONSIBILITY FOR THE ACTIVITIES LISTED. INDICATE THE NUMBER OF HOURS PER MONTH SPENT COMPLETING THESE ACTIVITIES.

ACTIVITY	NAME OF STAFF MEMBER	HOURS PER MONTH
APPROVE INCOME ELIGIBILITY FORMS (IEFs)		
OBTAIN ENROLLMENT FORMS AND UPDATE ANNUALLY		
PROVIDE TRAINING TO KEY STAFF		
CONDUCT CACFP ORIENTATION FOR NEW STAFF		
PLAN MENUS		
DOCUMENT FOOD AND LABOR COSTS		
COMPILE THE CLAIM FOR REIMBURSEMENT		
SUBMIT THE CLAIM ON-LINE		
OBTAIN AND UPDATE INFANT FEEDING PREFERENCE FORMS FOR ALL INFANT MEALS		
MONITOR CENTERS		

MONITORING AND REVIEWS

THE SPONSOR IS REQUIRED TO MONITOR EACH FACILITY UNDER ITS SPONSORSHIP AT LEAST THREE TIMES PER YEAR, IN ACCORDANCE WITH CACFP POLICY 6.3.

ARE MONITORING VISITS DOCUMENTED?

☐ YES ☐ NO

ARE AT LEAST TWO MONITORING VISITS PER YEAR UNANNOUNCED?

☐ YES ☐ NO

DOES THE MONITORING REVIEW INCLUDE A REVIEW OR OBSERVATION OF THE FOLLOWING REVIEW KEY ELEMENTS?

MENUS

☐ YES ☐ NO

ATTENDANCE IN REQUIRED TRAINING

☐ YES ☐ NO

MEAL RECORDS

☐ YES ☐ NO

ENROLLMENT FORMS AND ANNUAL UPDATE

☐ YES ☐ NO

MEAL PATTERN COMPLIANCE

☐ YES ☐ NO

FIVE DAY RECONCILIATION OF MEALS

☐ YES ☐ NO

MEAL COUNTING PROCEDURES/POINT OF SERVICE MEAL COUNTS

☐ YES ☐ NO

ACTIONS TAKEN TO CORRECT PREVIOUS PROBLEMS

☐ YES ☐ NO

LICENSE STATUS AND EXPIRATION

☐ YES ☐ NO

SANITATION OF FACILITIES

☐ YES ☐ NO

THE SPONSOR IS REQUIRED TO HAVE A POLICY REGARDING OUTSIDE EMPLOYMENT OF STAFF WORKING FOR THE SPONSOR AT ANY OF ITS FACILITIES.

IS THE POLICY AVAILABLE FOR REVIEW BY THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES?

☐ YES ☐ NO

DOES THE SPONSOR ASSURE THAT THE OUTSIDE EMPLOYMENT DOES NOT INTERFERE OR CONFLICT WITH THE PERFORMANCE OF CACFP DUTIES?

☐ YES ☐ NO

TRAINING

THE SPONSOR IS REQUIRED TO TRAIN KEY ADMINISTRATIVE AND OPERATIONAL STAFF ON CACFP RELATED ISSUES.

IS TRAINING OFFERED AT LEAST ANNUALLY?

☐ YES ☐ NO

IS THE TRAINING DOCUMENTED, INCLUDING THE NAME OF THE TRAINER, AND DATE OF THE TRAINING, THE TOPICS PROVIDED, AND THE PARTICIPANTS IN ATTENDANCE?

☐ YES ☐ NO

DOES THE TRAINING INCLUDE, AT A MINIMUM, THE FOLLOWING TOPICS, IN ACCORDANCE WITH CACFP POLICY 6.3?

☐ YES ☐ NO

CACFP MEAL PATTERN REQUIREMENTS

☐ YES ☐ NO

THE REIMBURSEMENT PROCESS

☐ YES ☐ NO

INFANT MEAL PATTERN REQUIREMENTS

☐ YES ☐ NO

MEAL COUNTING PROCEDURES

☐ YES ☐ NO

CREDITABLE FOODS

☐ YES ☐ NO

CLAIM CONSOLIDATION AND SUBMISSION

☐ YES ☐ NO

REQUIREMENTS FOR DOCUMENTING CHILD AND INFANT MEALS

☐ YES ☐ NO

FOOD SAFETY AND SANITATION

☐ YES ☐ NO

CACFP RECORDKEEPING REQUIREMENTS

☐ YES ☐ NO

NUTRITION

☐ YES ☐ NO

PERSONAL INFORMATION

PLEASE ENTER THE NAME, ADDRESS, TELEPHONE NUMBER AND DATE OF BIRTH OF THE PERSON COMPLETING THIS APPLICATION.

NAME:

ADDRESS:

PHONE NUMBER: ()

DATE OF BIRTH:

SIGNATURE

SIGNATURE BY THE AUTHORIZED REPRESENTATIVE (S) BELOW CERTIFIES THAT:

- A. The information on the application is true and correct to the best of my knowledge.
- B. The authorized representative(s) accept final administrative and financial responsibility for the total CACFP operation at the facility, if not under a sponsoring organization.
- C. Reimbursement will be claimed only for meals and snacks served to enrolled participants.
- D. Department officials may verify information.
- E. The authorized representative(s) understand that information is being given in connection with the receipt of federal funds, and that deliberate misrepresentation may subject the authorized representative(s) to prosecution under applicable state and federal criminal statutes.
- F. The above named facility insures that all participants enrolled in the facilities described on the application form are served the same meals regardless of race, color, national origin, age, sex, or disability, and there is no discrimination in the course of the meal service.
- G. For pricing facilities, meals will be available to all enrolled participants. A separate charge will be made for the meals. For non-pricing facilities, meals will be made available to all enrolled participants at no separate charge.
- H. All materials related to the program will contain the following nondiscrimination statement and complaint procedures:
- *In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.*
 - *To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.*
- I. The above named center or facility, and any of its directors, owners, board members, or other principals of the organization, have not been disqualified from participation in any publicly funded program for violating that program's requirements during the past seven years.
- J. During the past seven years, the board members, owners, directors, or other principals of the organization have not been convicted of any crime indicating a lack of business integrity, such as fraud, antitrust violations, theft, forgery, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, obstruction of justice or any other activity indicating a lack of business integrity as determined by the state agency.
- K. If the sponsoring organization is a for-profit organization, the centers under its sponsorship share the same legal entity as the sponsoring organization.
- L. Only for-profit centers meeting the 25% standard will submit a claim for reimbursement, or will be included in the sponsoring organization's claim for reimbursement. The institution or the sponsoring organization will indicate on the monthly claim the total number of participants which are Title XX and/or Title XIX beneficiaries.

SIGNATURE OF OWNER OR BOARD PRESIDENT		SIGNATURE OF CENTER DIRECTOR OR OTHER AUTHORIZED REPRESENTATIVE (person authorized to sign CACFP claims for reimbursement)	
TITLE/POSITION	DATE	TITLE/POSITION	DATE
PRINT OR TYPE NAME OF OWNER OR BOARD PRESIDENT		PRINT OR TYPE NAME OF CENTER DIRECTOR OR OTHER AUTHORIZED REPRESENTATIVE	
SOCIAL SECURITY NUMBER	DATE OF BIRTH (REQUIRED)	SOCIAL SECURITY NUMBER	DATE OF BIRTH (REQUIRED)
MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES USE ONLY			
APPROVED BY:	TITLE	DATE	EFFECTIVE DATE